



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

KINDRED HOSPITAL BAY AREA

Respondent Name

TEXAS PROPERTY & CASUALTY INSURANCE
GUARANTY ASSOCIATION

MFDR Tracking Number

M4-16-2143-01

Carrier's Austin Representative

Box Number 50

MFDR Date Received

March 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Kindred is a long-term acute care hospital, and the Division of Workers' Compensation . . . has not issued fee guidelines applicable to the long-term acute care Kindred provided to the Patient. Accordingly, the reimbursement rate for Kindred's claim should not have been tied to Medicare DRG, and instead should have been paid at a rate that is 'fair and reasonable.' . . . Kindred seeks reimbursement in this matter at a rate of 72% of billed charges (or \$108,645.34), which is fair and reasonable under 28 T.A.C. § 134.1. Specifically, this rate is consistent with the calculations used in prior payments to Kindred for similar services by representative Texas workers' compensation carriers in 2015, as reflected in the spreadsheet attached to Kindred's MFDR Request as Exhibit E."

Amount in Dispute: \$52,517.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Long Term Acute Care charges are not covered by the DWC Inpatient Hospital Fee Schedule. Therefore, according to DWC Rules 133.240(g) and 134.1(g) we have applied our consistently used methodology for reimbursing LTAC charges. We have allowed 150% of the Medicare allowance for these services."

Response Submitted by: Review Med, on behalf of Texas Property & Casualty Insurance Guaranty Association

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2015 to March 24, 2015	Long-Term Acute Care Hospital Services	\$52,517.36	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions regarding medical reimbursement.
3. 28 Texas Administrative Code §134.403 sets out the *Hospital Facility Fee Guideline—Inpatient*.
4. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
 - Reimbursement based on usual, customary and reasonable for this geographic region
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - Reimbursement was based upon the Medicare PPS LTCH.
 - W3 – [No description was provided for this payment reduction code.]

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. Has the requestor justified that the payment amount sought is a fair and reasonable rate of reimbursement?

Findings

1. This dispute regards long-term acute care (LTAC) hospital services not addressed in the Division's *Hospital Facility Fee Guideline—Inpatient*. 28 Texas Administrative Code §134.403(f) requires the use of Medicare's Inpatient Prospective Payment System (IPPS) to calculate the MAR for acute care hospital services—but Medicare does not reimburse LTAC hospitals under the IPPS; thus, the MAR for LTAC services cannot be calculated under Rule §134.403(f). The Division has not established a fee guideline for LTAC hospital services; consequently, reimbursement for these disputed services is subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1.

28 Texas Administrative Code §134.1(e) requires that medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with: (1) the Division's fee guidelines; (2) a negotiated contract; or (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in §134.1(f). As there is no applicable fee guideline for LTAC services and no documentation was found to support a negotiated contract, the applicable rule for determining reimbursement of the disputed services is Rule §134.1(f) regarding a fair and reasonable reimbursement.

2. In the following analysis, the position of the requestor is examined to determine if the burden is met to support that the amount sought is a fair and reasonable reimbursement for the services in dispute. If that burden is met, the position of the respondent will in turn be examined to determine whether the amount paid was fair and reasonable. The standard of proof required is by a preponderance of the evidence.

28 Texas Administrative Code §134.1(f) requires that:

Fair and reasonable reimbursement shall:

- (1) be consistent with the criteria of Labor Code §413.011;
- (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
- (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 South Western Reporter Third 656 (Texas 2004).

Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 South Western Reporter Third 104 (Texas Appeals – Austin 2003, petition for review denied), that “each . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)’s definition of ‘fair and reasonable’ fee guidelines as implemented by Rule 134.1 for case-by-case determinations.”

Texas Labor Code §413.011(d) requires that:

Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.”

Review of the submitted documentation finds that:

- The requestor states, “Kindred seeks reimbursement in this matter at a rate of 72% of billed charges (or \$108,645.34), which is fair and reasonable under 28 T.A. C. § 134.1.”
- The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline* (22 Texas Register 6271), “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors.” The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they “allow the hospitals to affect their reimbursement by inflating their charges” (22 Texas Register 6268-6269). The above principle is of similar concern here. Payment of a hospital’s “usual and customary” charges (or a percentage of those charges) is not acceptable when it leaves the ultimate reimbursement in the control of the health care provider — which would ignore the objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. Therefore, the use of a health care provider’s charges — or a percentage thereof — cannot be favorably considered unless other documentation or data is submitted to support that the payment amount sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor states “Specifically, this rate is consistent with the calculations used in prior payments to Kindred for similar services by representative Texas workers’ compensation carriers in 2015, as reflected in the spreadsheet attached to Kindred’s MFDR Request as Exhibit E.”
- Exhibit E is a spreadsheet documenting a number of payments from various workers’ compensation payors listing the corresponding billed charges and the percentage of billed charges reimbursed for each.
- Exhibit E does not support that the 72% rate is consistent with any of the individual amounts paid. The 72% factor is the mean of all the sample reimbursement percentages averaged together—ranging from a low of 20% to a high of 100%. However, none of the individual sample bills was reimbursed at the specific rate of 72%.
- The requestor states the requested 72% “rate is consistent with the calculations used in prior payments;” however, no documentation was presented to support what calculations were used in prior payments. The requestor did not provide copies of redacted explanations of benefits or other information to show how the various payors calculated any of the sample payments or to support that the payors used a methodology similar to that proposed by the requestor in determining their reimbursement amounts.
- The requestor states the spreadsheet is representative of “payments to Kindred for similar services;” however, the requestor did not provide copies of redacted bills or other documentation to support that the services compared on the spreadsheet were substantially similar to the services in dispute.

- The sample payments show a broad range of reimbursed percentages, exhibiting a great diversity in reimbursement. The requestor did not explain or show how the proposed methodology would ensure that similar procedures provided in similar circumstances would receive similar reimbursement.
- The requestor did not support that the proposed methodology meets the criteria of Labor Code §413.011 — the requestor did not explain how the proposed methodology ensures the quality of medical care or controls medical costs.
- The requestor has not demonstrated that the proposed reimbursement methodology would satisfy the requirements of §134.1(f).
- The requestor has not supported that the payment amount sought would result in a fair and reasonable reimbursement for the services in dispute.

The requestor's position is not supported. Review of the submitted information finds the requestor has not met the burden to discuss and present documentation to demonstrate and justify that the payment amount requested is a fair and reasonable rate of reimbursement in accordance with Rule §134.1. Consequently, additional payment is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care, the role of the Division is to adjudicate the payment, given the relevant statutory provisions and Division rules. The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent at the time of review. Even though all the evidence was not discussed, it was considered.

The applicable rule for determining reimbursement of the disputed long-term acute care hospital services is 28 Texas Administrative Code §134.1 regarding a fair and reasonable reimbursement. Upon review, the evidence presented by the requestor was not persuasive. The Division concludes the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

_____	Grayson Richardson	June 10, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

_____	Martha Luévano	June 10, 2016
Signature	Medical Fee Dispute Resolution Director	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.